Appendix A

Individualized Health Care Plans

Emergency Plan Procedure Information Sheet Daily Log

Medical Order Forms

Parent Authorization Form

Components of an Individualized Health care Plan

Who should have an Individualized Health care Plan (IHP)?

Students with mild to severe health care needs and require frequent nursing services at school should have an IHCP.

What is the purpose of an IHP?

The IHP helps assure consistent, safe health care for the student, protects the school nurse in legal proceedings, and provides documentation regarding the extent of services provided. Each IHP should be individualized to meet the needs of the student.

What should the IHP include?

The IHP should include the following four components:

- 1. Nursing assessment
- 2. Nursing diagnoses
- 3. Nursing interventions
- 4. Expected outcomes

Each IHP may include additional components to meet the needs of the student. The IHP should be revised when the student's physical condition or care changes. Each IHP should be consistent with minimum standards of care.

IHPs also should address:

- Physical education classes, if appropriate
- Special activities (i.e., swimming)
- Field trips
- Classroom parties
- Off-campus work opportunities
- Bus transportation
- Medical equipment, supplies, and services

Who should develop and sign the IHP?

Oklahoma Guidelines for Health care Procedures

in Schools

The following individuals should help develop and then sign the IHP:

- Parents/Guardians
- Student
- Medical provider (optional)
- Registered school nurse

Parents or legal guardians **must** authorize, in writing, care provided for their minor children.

Medical providers (physicians, nurse practitioners, physician assistants) **must** provide written orders for medical treatments provided at school.

How often should the IHP be updated?

The IHP should be updated as appropriate and revised at least annually (i.e., at least once each school year) or after significant changes occur in the student's health status.

What is the Emergency Care Plan or Emergency Action Plan?

The Emergency Care Plan (ECP) is required when a chronic condition has the potential to result in a medical emergency. The ECP is a component of the IHP.

Components of an Individualized Health Care Plan (IHP)

1. Assessment

The assessment provides the background information for the IHP and includes:

- Health history
- Current health status
- Self-care skills/needs
- Psychosocial status
- Health issues related to learning

2. Nursing Diagnosis

A nursing diagnosis summarizes the current health status of the student based on the student's response to the health condition and defines what the school nurse can contribute as an autonomous practitioner.

3. Goals

Goals are clear, concise, realistic descriptions of desired outcomes. They may be short-term or long-term but they must be measurable.

4. Nursing Interventions

A nursing intervention is any treatment performed to reach a goal or desired outcome.

5. Student Outcome

An outcome describes what the student is expected to do. It must be realistic and measurable.

6. Evaluation

The evaluation consists of periodically reviewing the student's goals and outcomes; comparing actual versus predicted outcomes; reviewing the interventions; and, if necessary, modifying the IHP. Evaluations also should occur when the student's health status changes significantly or when the medical provider changes the student's prescribed treatment or medications.

Sources:

National Association of School Nurses. (2015). *Individualized health care plans: The role of the school nurse* (Position Statement). Silver Spring, MD: Author.

Schwab, N. (2005). Legal issues in school health services: A resource for school administrators, school attorneys, school nurses. Authors Choice Press.

$Individualized \, Health \, care \, Plan \, (IHP)$

Student:			
	Name	I	Date of Birth
Prepared By:			
	School Nurse or (Title)	I	Oate
Approved By:	:		
	Parent/Guardian(s)	I	Date
	Parent/Guardian(s)	I	Date
Approved By:	:		
	Student	I	Date
Annroved By:	:		
11pp10v0uDy.	Medical Provider (optional)	I	Date
N D			
Next Review &	& Revision Due:		

Individualized Health care Plan

Demographics Student Name_____Birth Date _____ Home Address Home Phone Parent/Guardian Phone _____ Parent/Guardian _____Phone _____ Caregiver _____ Language Spoken at Home **Emergency Contacts:** Name Relationship Phone Name Relationship Phone Oklahoma Guidelines for Healthcare Procedures in Schools

Medical Care

Primary Health care Provider	Phone	
Specialty Health care Provider	Phone	
Health History		
Brief Health History		
Bilet Health History		
Special Health care Needs		

Current Health Status (Baseline status, e.g., skin color/integrity, vital signs, mobility)
Student Participation in Care
Health Issues Related to Learning
Activity Considerations (physical education, field trips, extracurricular activities)
Equipment, Supplies, Services

Other considerations		

Medication & Dietary Needs

Current Medications (dose, route, time)				
Special Dietary Requirements				
special Dictary requirements				
Allergies (include type of reaction)				

Individualized Health Care Plan - Components

	Expected Outcomes

Procedures

Procedure	
Frequency	Times
Position of student during procedure	
Ability of student to assist/perform procedure	
Location for procedure	
Equipment needed	
Procedural considerations & precautions	
Staff qualified to assist with procedure	

Daily Log

Student Name	Class/Grade		
Procedure			
Parent	Phone		

Date/Time	Procedure notes	Observations	Time for Prep, Proc, Doc	Completed by

Emergency Care Plan (or Emergency Action Plan)

Student Name	Class/Grade
Parent/Guardian	Phone
Parent/Guardian	Phone
Health care Provider	Phone
If you see this	Do this
In an emergency occurs:	
 Stay with child Call or have someone else call the school nurse If the school nurse is not available, the following staf plan. 	f members are trained to initiate the emergency care

Consent for Administration of Special Health Care Procedures

Student		Birth Date	School Year	
Primary Diagnosis			ICD-10	
Diagnosis	ICD-10	Diagnosis	ICD-10	
This form is used for specialized procedures which may include, but not be limited to administration of oxygen, urinary catheterization or wound care procedures which may be needed and provided for a student while he/she attends school. The procedure(s) may be performed by school personnel trained and supervised by a Licensed School Nurse.				
		uardian Authorization		
I authorize the school nurse		_	ncerning this medication/s.	
		·	Fax #	
 I understand that parent given at school. Prescri I understand that I must I understand all medicat (Please ask your health school, & one for home and directions. I will notify the school improcedure(s). The medication may not administered by school 	i/guardian authoriz ption medications provide all medications ions must be provitor provider for the manager of	ation is required for any premust have a physician or lition(s) and equipment for the ded with an accurately labeledication to be divided into medications must be in an ild s health status changes	escription medication to be censed authorization. ne procedure(s) below. eled prescription container. to two containers-one for original container with label or there is a cancellation of the se. The medications may be seed school nurse.	
Parent/Guardian Signature	9		_ Date	

Physician's Orders

Procedure			
Instruction			
Time/interval procedure is to be done _			
Amount (if applicable)			
Precautions and/or adverse reactions _			
Physician's Signature			
For office use only: LSN Signature			
Name of Staff Routing	Date		
Please check off who was routed this form	Student File IFP Mana	ger Building Nurse Other	

Consent for Administration of Special Health Care Procedures

Students with Special Health Care Needs TRANSPORTATION PLAN

Date: Is this Child on an IEP? Yes No
Student's Name
Route AM PM Driver:
Address
Parent/Guardians
HomeTelephone
Dad Daytime Phone Mom Daytime Phone
Babysitter's Name & Phone
School Teacher's Name
School's Phone Teacher's Aide

Medications Side Effects
Mode of Transportation
Walks up bus stairs independently No Yes
Student positioning and handling requirement: Seat # Wheelchair Position #
List student's/driver's method of communication
List any behavioral difficulties student displays (attach IEP behavioral goals)
List equipment that must be transported on bus including oxygen, lifesustaining equipment, wheelchair equipment, etc
Does the student require life sustaining equipment? Yes No If yes, see attached protocol
Special diet, food allergies
Comments

Students With Special Health Care Needs

EMERGENCY PLAN

Students Name	Date	
Physician	Phone #	

IF AN EMERGENCY OCCURS AND IS LIFE-THREATENING, IMMEDIATELY CALL 9-1-1 (Use the bus radio to contact the transportation office , so they can activate 9-1-1

STUDENT SPECIFIC EMERGENCIES

IF YOU SEE THIS	DO THIS



Student:	Grade:	School Contact	DC	DOB: MCell #: PCell #:	
Mother:	MHome #:	MWork	.#:M		
Pather:	PHome #:	FWork	#:FC		
Emergency Contact:	Relati	ionship:	Phone:		
SYMPTOMS OF A HYPOGLYCEMIC EI Shaking, fast heartbeat, sweating, anxi Complaints of hunger, impaired vision Onset may be sudden and can prop	ety, irritability 1, weakness or fatig	rae	LL OF THESE:	Student Photo	
SEVERE SYMPTOMS INCLUDE: Appears very pale, feels faint, loss of c Seizure activity	consciousness				
STAFF MEMBERS INSTRUCTED: Administration	☐ Classroom ' ☐ Support Sta		☐ Special Area Teac ☐ Transportation St		
Accompany the student to the Health If off school grounds, provide a source 1/2 - 3/4 cup juice Glucose tabs Hard candy Regular soda (not diet!) Glucose gel Notify parents/guardian (do not delay	e of glucose:			t firstj.	
STEPS TO FOLLOW FOR A HYPOGLY Glucagon ordered: Yes No if Glucagon is ordered, it should be given by a unconscious, unresponsive or having a seizure After Glucagon is given, call 911. Notify pare Students receiving glucagon without their pare staff member should accompany the student to present and adequate supervision for other stu-	willing volunteer v nts Preferred Hosp nt or guardian pres o the emergency ro	who has been traine pital if transported: ent should be trans	sported to the hospita	l by ambulance. A	
Healthcare Provider		Phone:			
Written by:		Date:			
□ Copy provided to P	arent		lealthcare Provider		
Parent/Guardian Signature to share this pla This plan is in e		d School Staff:	er school as needed	Revised 1/0	



SEIZURE DISORDER

Student:	Grade:	School Contact:	DOB:
Mother	MHome #:	MWork #:	MCell #:
Pather:	PHome #:	FWork #:	PCell #:
Emergency Contact	Relation	iship:	Phone:
SYMPTOMS OF A SEIZURE EPISOD	E MAY INCLUI	DE ANY/ALL OF	THESE:
 Tonic-Clonic Seizure: Entire body stiffens, jerking 	movements		
May cry out, turn bluish, be			Student
☐ Absence Siezure:			Photo
 Staring spell, may blink eyes 			
STAFF MEMBERS INSTRUCTED:	☐ Classroom T	5.4	☐ Special Area Teacher(s)
☐ Administration	☐ Support Staf	f	☐ Transportation Staff
Place student on side if possible, spi Stay with student until help arrives Emergency Medical Services (91) Preferred Hospital if transported: Emergency medication to be g Student should be allowed to resi	l) should be called given by Nurse a	, student transported	i to hospital
Transportation Plan: Medication available Special instructions:		ion NOT available on	bus Does not ride bus
Healthcare Provider:		Phone:	
Written by:		Date:	
☐ Copy provided to P	arent 🔲	Copy sent to Health	care Provider
Parent/Guardian Signature to share this	plan with Provider	and School Staff:	
This plan is in effe	ect for the current school	ol year and summer scho	ool as needed Revised !



Student:	Grade	: School	Contact:	DOB:
Asthmatic: 🛭 Yes 🗆	No (increased risk for se	vere reaction) Sevi	erity of reaction(s):	
Mother:	100	MHome #:	MWork #:	MCell #:
Pather:		_ PHome #:	PWork #:	PCell #:
Emergency Contact:		Relation	nship:	Phone:
MOUTH THROAT SKIN STOMACH LUNG HEART	NALLERGIC REACTIO Itching & swelling of lip Itching, tightness in the Hives, itchy rash, swellin Nausea, abdominal cran Shortness of breath, rep "Thready pulse", "passi he severity of symptoms s important that treatm	os, tongue or mout oat, hoarseness, co- ng of face and extr nps, vomiting, diar setitive cough, whe ng out" ns can change q	h ugh emities rhea ezing uickly –	Student Photo
STAFF MEMBERS	INSTRUCTED: Administration	Classroom Te		cial Area Teacher(s) nsportation Staff
TREATMENT:	Remove stinger if visible	e, apply ice to area	Rinse o	ontact area with water.
Benadryl ordered:	nitiated with symptom Yes No	9	ting for symptoms Give Benadi	ryl per provider's orders
		THE RESERVE OF THE PARTY OF THE	G AT THE SITE OF	THE STING ARE PRESENT
Preferred Hospital if to Epinephrine provides rate. This is a normal member should accom	ransported: a 20 minute response wind response. Students receivi	low. After epineph ng epinephrine sho nergency room if th	nrine, a student may feel ould be transported to the	dizzy or have an increased heart e hospital by ambulance. A staff nergency contact is not present and
Transportation Plans Special instructions	: ☐ Medication available o	n bus 🗖 Medicat	ion NOT available on b	as Does not ride bus
Healthcare Provider			Phone	5
Written by			Date:	2
	Copy provided to Pare	ent C	Copy sent to Healthcan	
	gnature to share this plan v		School Staff:	
	This plan is in effect f	or the current school	year and summer school a	s needed. Revised 1/08



Mother:		MHome #:	MWork #:	MCell #:
				PCell #:
Emergency Contact:				- ALASSA
176 N			- The state of the	
	N ALLERGIC REACT			THESE:
• MOUTH		lips, tongue or mouth	The state of the s	
• THROAT		hroat, hoarseness, cou	-	
• SKIN	Control of the contro	elling of face and extre		Student
STOMACH LUNG		ramps, vomiting, diarr		Photo
- HEART		repetitive cough, whee	zing	
822	"Thready pulse", "pa			
	he seventy of sympto			
1t :	is important that trea	tment 15 give imm	ediately.	25
STAFF MEMBERS II	NSTRUCTED-	Classroom Teach	her(s) 🗆 So	pecial Area Teacher(s)
	☐ Administration	☐ Support Staff		ransportation Staff
		100		50
Treatment should be in Benadryl ordered:	Rinse contact area wi initiated with symp Yes No Il parent/guardian if off: Yes No Speci	Give school grounds.		r's orders
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Treatment should be in Benadryl ordered: Call school nurse. Call school nurse. Call prinephrine ordered: IF INGESTION AND EPIN Preferred Hospital if the Epinephrine provides rate. This is a normal member should accordadequate supervision. Transportation Plan Special instruction Healthcare Provider. Written by:	initiated with symp Yes No Il parent/guardian if off Yes No Specia OR SUSPECTED ING IEPHRINE IS ORDE: Transported: Tra	Giveschool grounds. al instructions: GESTION OF ALLI RED, GIVE EPINE indow. After epinephrine show emergency room if the ent deficit	ERGEN OCCURS, PHRINE IMMED tine, a student may feeld be transported to e parent, guardian or on NOT available on Phon Date: Copy sent to Health	SYMPTOMS ARE PRESENT IATELY AND CALL 911. el dizzy or have an increased heart the hospital by ambulance. A staff emergency contact is not present at bus. Does not ride bus



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• THROAT		hroat, hoarseness, cou		
• SKIN		elling of face and extre		Student
STOMACH		ramps, vomiting, diarri		Photo
• LUNG		repetitive cough, whee	zing	6,700,750,01
• HEART	"Thready pulse", "pa		412	
	he seventy of sympt			
iti	is important that trea	tment is give imme	ediately.	
STAFF MEMBERS II	NSTRUCTED-	Classroom Teach	ner(s)	Area Teacher(s)
	☐ Administration	☐ Support Staff		oortation Staff
		\$	•	
TREATMENT:	Rinse contact area w	ith water if appropriate	V.	
		11 1		
Treatment should be i	nitiated 🔲 with symp	stome mithout mai	tine for symptoms	
Benadryl ordered:			Benadryl per provider's o	rdorr
Demantyl otdered.	165 🖬 140	Give	benautyr per provider s o.	ideis
Call sehool purso. Cal	Il parent/guardian if off	school arounds		
	☐ Yes ☐ No Speci			
Epinepitime ordered.	a res a reo speci	at mistraccions.		
			ERGEN OCCURS, SYN	MPTOMS ARE PRESENT
		ALD, GIVE EFINE	THRINE IMMEDIAL	ELI AND CALL 711.
Preferred Hospital if t		indom: After enineabr	ing a student man feel di	zzy or have an increased heart
				hospital by ambulance. A staff
	for other students is pre-		parent, guardian or eme	rgency contact is not present at
adequate supervision	or other students is pre-	enc		
Transportation Dlan	D Mediantian amilabl	and her Different	on NOT available on bus	D. Door not side bor
Transportation Flan	. Medication available	e on ous a menican	on ivor available on bus	Does not nice out
Special instructions	S:			
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Healthcare Provider:			Phone:	
Written by:			Date:	
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Parent/Guardian Sig	gnature to share this pla	n with Provider and So	chool Staff:	
	This plan is in A	et for the correct school .	ear and summer school as i	needed. Revised 1/0
	I ms pian is in effe	a jui tue current school)	eur una summer school as l	retuen. Revised 1/0

Student:	Gra	de: School (ontact:		DOB:
Mother:	89.17	MHome #:	MWork	#:	MCell #:
Father:		PHome #:	FWork #	#:	FCell #:
Emergency Contact:		Relations	hip:	Phone	<u>-</u>
MOUTH THROAT SKIN STOMACH LUNG HEART	Itching, tightness in the Hives, warmth, itchy Nausea, abdominal cr	lips, tongue or mouth hroat, tightness in che- rash, generalized swell camps, vomiting and/o repetitive cough, whee- ssing out" oms can change qu	st ing or diarrhea zing ickly –	OF THESE:	Student Photo
STAFF MEMBERS		☐ Classroom Tea	cher(s)	☐ Special Area ☐ Transportatio	
TREATMENT:	Rinse contact an	ea with water.			
Benadryl ordered:	□ Yes □	No G	live	Benadryl per pr	ovider's orders
Call school nurse at		Call parent/guar	dian if off schoo	ol grounds.	
Epinephrine ordered:	□ Yes □ :	No Special instructio	ns:		
Preferred Hospital if tr Epinephrine provides a rate. This is a normal a member should accom	is ORDERED, GIVE ansported: a 20 minute response wi response. Students recei	EPINEPHRINE IN andow. After epinephriving epinephrine shou emergency room if the	ine, a student ma	Y AND CALL! ay feel dizzy or l d to the hospital	
Transportation Plan: Special instructions	☐ Medication available	e on bus 🔲 Medicatio	on NOT availabl	e on bus 🚨 D	oes not ride bus
Healthcare Provider:			33	Phone:	
Written by:	☐ Copy provided to P	arent 🗅	- 1	Date:	er
Parent/Guardian Sig	nature to share this plan This plan is in el	n with Provider and So fect for the current school	40.500 PEGF 11.50 N.W.FU	r school as neede	I. Revised 1/0

Student:	Grade: S	ichool Contact: _	DOI	В:
Asthma Triggers:		Best Peak	Flow:	20
Mother	MHome #:	MWork #	: MC	ell #:
Pather	PHome #:	FWork #:		1#:
Emergency Contact:		161.507 to 1755.1	William Middle Co.	18511945
SYMPTOMS OF AN ASTHMA EPISODE CHANGES IN BREATHING: co shortness of breath, Peak Flow of < VERBAL REPORTS of: chest tight day mouth, "neck feels funny", doesn't APPEARS: anxious, sweating, nause over and cannot straighten up easily. SIGNS OF AN ASTHMA EMERGENCY: Breathing with chest and/or neck pull when inhaling. Difficulty in walking a Blue-gray discoloration of lips and/or Failure of medication to reduce worse Peak Flow of critical and control of the separations greater than 30/minute.	E MAY INCLUDE Al ughing, wheezing, breat ness, chest pain, cannot t feel well, speaks quiet ous, fatigued, stands wit ed in, sits hunched over not talking- fingernails. ning symptoms with no	NY/ALL OF The ching through more catch breath, by. h shoulders huncur, nose opens wide,	HESE: buth, hed	Student Photo
STAFF MEMBERS INSTRUCTED: Administration	☐ Classroom Teac ☐ Support Staff	1000 PM #1	Special Area Teach Transportation Sta	
TREATMENT: Stop activity immediately. Help student assume a comfortable position Encourage purse-lipped breathing. Encourage fluids to decrease thickness of In Give medication as ordered: Observe for relief of symptoms. If no relief Notify school murse at	ng secretions.	tes, follow steps b	elow for an asthma	
• Call 911 (Emergency Medical Services) and in physical symptoms, and what medications has • A staff member should accompany the stude present and adequate supervision for other s	nform the that you have e/she has taken and use nt to the emergency roo	ually takes. om if the parent, g	guardian or emergen	
Healthcare Provider:		Phone:		
Written by:		Date:		
☐ Copy provided to F	arent 🔲 (Copy sent to Hea	lthcare Provider	+0
Parent/Guardian Signature to share this pla	n with Provider and Sci	nool Staff:		
This blow is in effect to	or the correct school was	and commer cohon	l ar mardad	Paris at 10

	GLAUE.		
Asthma Triggers:		Best Peak Flow:	
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SYMPTOMS OF AN ASTHMA EPISO. CHANGES IN BREATHING: shortness of breath, Peak Flow of VERBAL REPORTS of: chest tig dry mouth, "neck feels funmy" doe APPEARS: anxious, sweating, nan over and cannot straighten up easily SIGNS OF AN ASTHMA EMERGENG Breathing with chest and/or neck p when inhaling. Difficulty in walkin Blue-gray discoloration of lips and/ Failure of medication to reduce wo Peak Flow of Respirations greater than 30/minute. Pulse greater than 120/minute.	DE MAY INCLUDE All coughing, wheezing, breat coughings, wheezing, breat coughiness, chest pain, cannot so't feel well, speaks quiet seous, fatigued, stands wit f CY: valled in, sits hunched over g and talking. 'or fingernails. rsening symptoms with no or below.	wy/ALL OF THESE: hing through mouth, catch breath, by. h shoulders hunched t, nose opens wide	Student Photo
STAFF MEMBERS INSTRUCTED:	☐ Classroom Tead ☐ Support Staff	\$50.000 mm = 100 mm =	l Area Teacher(s) portation Staff
Stop activity immediately. Help student assume a comfortable positi Encourage purse-lipped breathing. Encourage fluids to decrease thickness of Give medication as ordered: Observe for relief of symptoms. If no rel Notify school nurse at	lung secretions.	es, follow steps below fo	
STEPS TO FOLLOW FOR AN ASTHM Call 911 (Emergency Medical Services) an physical symptoms, and what medications A staff member should accompany the stu present and adequate supervision for other	d inform the that you have he/she has taken and usu dent to the emergency roo	ally takes. on if the parent, guardian	or emergency contact is not
Healthcare Provider:		Phone:	
Written by:		Date:	
☐ Copy provided to	o Parent 🔲 (Copy sent to Healthcare	Provider
Parent/Guardian Signature to share this			



Student:	Grade:	School Contact:	DOB:
Mother	MHome #:	MWork #:	MCell #:
Pather:	PHome #:	FWork #:	PCell #:
Emergency Contact	Relatio	onship:	Phone:
SYMPTOMS OF A HYPERGLYCEMIO Gradual Onset Extreme thirst, very frequent urinati Flushed skin, heavy breathing, bluzze Vomiting, fruity or wine-like odor to	on, drowsiness ed vision	AY INCLUDE ANY	Student Photo
SEVERE SYMPTOMS INCLUDE: Stupor Unconsciousness			
STAFF MEMBERS INSTRUCTED: Administration	☐ Classroom ☐ Support St		☐ Special Area Teacher(s)☐ Transportation Staff
TREATMENT: Stay with the student. Notify school murse immediately. Call 911 to access Emergency Me Preferred Hospital if transported: Notify parents/guardian (do not del	-7A		
Healthcare Provider:		Phone:	
Written by: Copy provided to Pa	urent	Date: Copy sent to Health	
Parent/Guardian Signature to share this p	plan with Provid	er and School Staff: _	
This plan is in effe	ct for the current sch	ool year and summer scho	nol as needed Revised 1/08